DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 2

2. STATE: Distri of Columbia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 702 of BIPA 2000

7. FEDERAL BUDGET IMPACT: mse per DC Auth 9-17-01
a. FFY 2001 $ None
b. FFY 2002 $ 590,299

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Pg. 6d, 6e mse per DC Auth. 9-17-01

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B Pg. 6c, 12. b. mse per au 9-18-01

10. SUBJECT OF AMENDMENT:
Prospective Payment for FQHCs

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☒ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Sandra X. Rucker for HHW

13. TYPED NAME:
Herbert H. Weldon, Jr.

14. TITLE:
Senior Deputy Director

15. DATE SUBMITTED:
March 30, 2001

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 30, 2001

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V. Campbell

21. TYPED NAME:
Claudette V Campbell

22. TITLE: Associate Regional Admin.
Division of Medicaid + State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Region III

Suite 216, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-3499

SEP 26 2001

Herbert H. Weldon, Jr.
Senior Deputy Director
Department of Health
Medical Assistance Administration
825 North Capitol Street, NE
Fifth Floor
Washington, D. C. 20002

Dear Mr. Weldon:

Enclosed is a copy of the approved state plan material, Transmittal Number 01-02, that changes the District's payment methodology for reimbursement of Federally Qualified Health Center services to comply with the Benefits Improvement and Protection Act (BIPA) of 2000.

If you have any questions, please contact Marguerite Clark at (215) 861-4199.

Sincerely,

Claudette V. Campbell

Claudette V. Campbell
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosure

cc: Ted Gallagher (w/encl.)
Suzan Stecklein
Elliot Weisman (w/encl.)

12.

b. Federally Qualified Health Centers (FQHCs)

Effective for services furnished by FQHCs on January 1, 2001 and thereafter, reimbursement for these services will be in conformance with the prospective payment system, which is outlined in Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. If an inconsistency between the descriptions in this section 12.b. and Section 702(a) and 702(b)(1) through 702(b)(5) of BIPA is discovered, the meaning of the language in BIPA will take precedence. The following paragraphs include a detailed description of the method and definitions of specific terms used in the description:

DEFINITIONS:

Federally Qualified Health Center (FQHC) – An entity that meets the definition at Section 1905(l)(2)(B) of the Social Security Act.
Fiscal year (FY) – will be defined as the District's fiscal year.
Prospective rate – the rate paid for services furnished in a particular fiscal year. The rate is not dependent on actual cost experience during the same year in which the rate is in effect.
Allowable Costs – the reasonable costs that are incurred by an FQHC in furnishing Medicaid-coverable services to Medicaid eligible patients (defined in the D.C. State Medicaid Plan), as determined by Medicare Reasonable Cost Principles.
Medicare Reasonable Cost Principles – The cost principles described at section 413 in Title 42 of the Code of Federal Regulations. Further interpretation of these principles is found in the Medicare Provider Reimbursement Manual.
Inflation factor – The percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3), and applicable to primary care services as defined in section 1842(i)(4). The inflation factor will be applied on a fiscal year basis starting with services furnished on or after October 1, 2001.
Visit – every patient encounter in an FQHC when one or more medical services are furnished to that patient.
Increase or decrease in scope of services – A change in the type, intensity, duration, and/or amount of services. A change in the cost of a service, in and of itself, is not considered a change in the scope of services.

DESCRIPTION OF REIMBURSEMENT METHODOLOGY:

(1) For FQHCs in existence in 1999 and 2000 – Each FQHC will be paid a prospective rate for each visit or encounter with a Medicaid recipient when a medical service or services are furnished. The prospective rate effective beginning January 1, 2001 through and including September 30, 2001, will be computed in the following manner:

(a) The FQHC's allowable costs for FYs 1999 and 2000 will be totaled and the resulting dollar amount will be divided by the FQHC's total patient visits in FYs 1999 and 2000. The resulting

rate, adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC during fiscal year 2001, will be the prospective rate paid to the FQHC for services that it furnishes in fiscal year 2001. The amount of the adjustment shall be at a negotiated rate, and the District shall implement a revision to an FQHC's rate not later than 90 days after the establishment of the negotiated rate. The FQHCs are responsible for reporting to the District an increase or decrease in the scope of services and the starting date of such a change. The District will specify the reporting format and content.

(b) For services provided in fiscal year 2002 and in each fiscal year thereafter, the prospective rate will be computed by taking the FQHC's prospective rate that was in effect in the previous fiscal year and (1) increasing the rate by the applicable inflation factor for that fiscal year and (2) adjusting the rate to take into account any increase or decrease in the scope of such services furnished by the FQHC during the fiscal year. The amount of the adjustment shall be at a negotiated rate and the District shall implement a revision to an FQHC's rate not later than 90 days after the establishment of the negotiated rate. The FQHCs are responsible for reporting to the District an increase or decrease in the scope of services and the starting date of such a change. The District will specify the reporting format and content.

(c) Interim payments- Each FQHC shall receive interim payments until completion of the required audit to establish allowable costs. The interim payments shall be determined in accordance with the same methodology set forth in the District's State Plan on the day preceding the effective date of this State Plan amendment.

(2) For entities that qualify as an FQHC after fiscal year 2000 – The prospective payment rates for services furnished in the first year that an entity qualifies as an FQHC will be equal to the average of the prospective rates paid to other FQHCs located in the same area with a similar case load. For each fiscal year following the first year in which the entity first qualified as an FQHC, the prospective payment rate shall be computed in accordance with the previous section 12.b.(1)(b).

(3) Reimbursement for an FQHC that furnishes services to Medicaid recipients under a contract with a managed care entity - When an FQHC furnishes services to Medicaid recipients under a contract with a managed care entity (as defined in section 1932(a)(1)(B), and receives a smaller payment from the managed care entity than it would be entitled to receive under 12.b. of this State Plan, the District's Medicaid Program will make a supplemental payment to the FQHC so that its total reimbursement for services (the combination of the reimbursement received from the managed care entity and from the Medicaid program) will be equal to the amount it would have been entitled to receive under 12.b. if it had not been under contract with the managed care entity. The supplemental payment will be made on a quarterly basis. In order for the District to compute the quarterly supplemental payment, an FQHC will be required to submit information about the amount of payments it has received from MCOs for Medicaid enrollees for a specified time period. The District will specify the exact content and format of this information.